Employer Insurance Eligibility Form

(To be completed by employer or employer contact)

Employee Name _____ Employee Title _____

Employee Hire Date _____ Employer Name _____

Employer Address _____ Employer Contact Name _____

_____ Title _____

_____ Phone # _____

I, _____, certify that _____ is a full-time employee.
(Employer Contact) (Employee Name)

I, _____, certify that _____ is a part-time employee.
(Employer Contact) (Employee Name)

(Please check all that apply)

Does your company offer health insurance to full-time employees?

☐ Yes ☐ No

If yes, what health insurance benefits are available to full-time employees?

☐ Medical ☐ Dental ☐ Prescription ☐ Discount Plan Only

Does your company offer health insurance to part-time employees?

☐ Yes ☐ No

If yes, what health insurance benefits are available to part-time employees?

☐ Medical ☐ Dental ☐ Prescription ☐ Discount Plan Only

Please complete this section in its entirety if your company offers insurance to this employee.

Is this employee currently eligible for healthcare offered by your company? ☐ Yes ☐ No

If no, why? _____ **(please continue to the signature section)**

If yes, is this employee currently enrolled in healthcare offered by your company? ☐ Yes ☐ No

If no, is employee eligible to enroll at this time? ☐ Yes ☐ No

If no, when will employee be eligible to enroll in healthcare? ____/____/____. After the employee enrolls, insurance will begin ____/____/____.

By signing this document, I verify all of the information provided above is accurate.

_____ _____

Employee Signature Date Employer Contact Signature Date

Revised: April 30, 2015